Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Advisor on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
## Contents

1. **Background**  
   Bookmark not defined.

2. **A summary of our inspection**  
   6

3. **What we found during this inspection**  
   9

**Appendix 1 – Areas for improvement**  
28

**Appendix 2 – Details of inspection**  
30

**Appendix 3 – List of national guidance**  
31

**Appendix 4 – Inspection process flow chart**  
32

**Appendix 5 – Terms we use in this report**  
33
1 Background

In June 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced that Healthcare Improvement Scotland would carry out a new programme of inspections. These inspections are to provide assurance that the care of older people in acute hospitals is of a high standard. We measure NHS boards against a range of standards, best practice statements and other national documents relevant to the care of older people in acute hospitals, including the Clinical Standards Board for Scotland (CSBS) Clinical Standards for Older People in Acute Care (October 2002).

Our inspection process is focused on the three national quality ambitions for NHSScotland, which aim to ensure that all care is person-centred, safe and effective. The process includes a planned NHS board visit which allows them to highlight areas of good practice and also areas where improvements could be made. The NHS board visit is then followed up by an inspection to each acute hospital in the NHS board area. We also look at outcomes relating to one or more of the following areas on each inspection:

- treating people with compassion, dignity and respect
- screening and initial assessment
- person-centred care planning
- safe and effective care
- managing the return home, and
- leadership and accountability.

We are working closely with improvement colleagues in Healthcare Improvement Scotland to ensure that NHS board teams are given appropriate support to deliver improvements locally and to share and learn from others.

During our inspections, we identify areas where NHS boards:

- **must** take action in a particular area, or
- **should** take action in a particular area.

If we tell an NHS board that it **must** take action, this means the improvements we have identified are linked to national standards, other national guidance and best practice in healthcare. A list of relevant national standards, guidance and best practice can be found in Appendix 3.

If we tell an NHS board that it **should** take action, this means that, although the improvements are not directly linked to national standards, guidance or best practice, we consider the care that patients receive would be improved.

**About this report**

This report sets out the findings from our unannounced inspection to Victoria Hospital, NHS Fife from Tuesday 17 to Thursday 19 February 2015.

This report summarises our inspection findings on page 6. Detailed findings from our inspection can be found on page 8.
The inspection team was made up of four inspectors and two public partners, with support from a project officer. One inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached. A key part of the role of the public partners is to talk with patients about their experience of staying in hospital and listen to what is important to them. Membership of the inspection team visiting Victoria Hospital can be found in Appendix 2.

The report highlights areas of good practice and areas for improvement. You can find all areas for improvement from this inspection in Appendix 1 on page 28.

The flow chart in Appendix 4 summarises our inspection process. More information about Healthcare Improvement Scotland, our inspections, methodology and inspection tools can be found at http://www.healthcareimprovementscotland.org/OPAH.aspx
A summary of our inspection

Victoria Hospital, Kirkcaldy, serves Kirkcaldy and the surrounding region. It contains approximately 640 staffed beds and has a full range of healthcare specialties. A new expansion to Victoria Hospital opened in January 2012 as part of plans to reconfigure acute services across NHS Fife.

We carried out an unannounced inspection to Victoria Hospital from Tuesday 17 to Thursday 19 February 2015.

We inspected the following areas:

- admissions unit 1 (AMAU)
- ward 6 (surge capacity)
- ward 12 (care of the elderly)
- ward 15 (care of the elderly/rehabilitation)
- ward 23 (cardiology)
- ward 42 (stroke unit)
- ward 44 (general medicine), and
- ward 53 (surgical).

Before the inspection, we reviewed NHS Fife’s self-assessment and gathered information about Victoria Hospital from other sources. This included Scotland’s Patient Experience Programme, and other data that relate to the care of older people. We also carried out an NHS board visit to NHS Fife on Thursday 13 November 2014. Based on our review of this information, we focused the inspection on the following outcomes:

- treating people with compassion, dignity and respect
- screening and initial assessment
- person-centred care planning
- safe and effective care
- managing the return home, and
- leadership and accountability.

On the inspection, we spoke with staff and used additional tools to gather more information. In all wards, we used a formal observation tool and the mealtime observation tool, where appropriate. We carried out 14 periods of observation during the inspection. In each instance, members of our team observed interactions between patients and staff in a set area of the ward for 20 minutes.

We also carried out patient interviews and used patient and carer questionnaires. We spoke with 37 patients during the inspection and one carer. We received completed questionnaires from 30 patients and 18 family members, carers or friends.

As part of the inspection, we reviewed 34 patient health records to check that the care we observed was informed by the outcomes of the assessments and as described in the care plans.
Areas of strength
We noted that NHS Fife has made significant improvements following previous inspections in May and December 2013 and June 2014. However, we acknowledge that NHS Fife still has work to do.

Some of these strengths include:

- the completion of adults with incapacity documentation
- the completion of assessments for patients on admission to hospital, and
- applying the principles of dementia environmental design when upgrading clinical areas.

Areas for improvement
We found that further improvement is required in the following areas:

- the development of treatment plans for patients who lack capacity to consent, and
- the completion of food and fluid balance charts.

What action we expect the NHS board to take after our inspection
This inspection resulted in 10 areas for improvement and nine areas of good practice. A full list of the areas for improvement can be found in Appendix 1 on page 28.

We expect NHS Fife to address all the areas for improvement. The NHS board must prioritise those areas where improvement is required to meet a national standard.

The NHS board has developed an improvement action plan, which is available to view on the Healthcare Improvement Scotland website and the NHS board website for 16 weeks. After this time, the action plan can be requested from Healthcare Improvement Scotland http://www.healthcareimprovementscotland.org/OPAH.aspx

We would like to thank NHS Fife and in particular all staff at the Victoria Hospital for their assistance during the inspection.
3 What we found during this inspection

3.1 Treating older people with compassion, dignity and respect

All patients were cared for in either single rooms or single sex bays. The majority of rooms had ensuite toilet facilities and ward access to baths and showers. Wards in the older parts of the hospital did not have ensuite toilets and bathroom facilities in each room. However, there were separate male and female toilets, and bath and shower facilities, in the ward areas.

Wards inspected were light, bright and fresh smelling. We also noted that the majority of ward corridors were clear and free from obstructions and clutter. All wards inspected had a nurse call system in use. We saw that the call buttons were placed near to patients to make them more accessible and requests for assistance were met promptly. Personal items, such as glasses and hearing aids, were easily accessible for patients. In some wards, we saw that patients had their own bedthrows, blankets, pillows and family photographs at their bedside. Familiar personal items can be comforting for patients when they are in a hospital setting.

We saw most patients were wearing their own clothes or nightwear. However, we saw that some patients were wearing hospital gowns. On discussion with nursing staff, we were told that if a patient is admitted with no night clothes or clean clothes, staff would routinely phone the patients next of kin or place of residence, for example a nursing home, to ask if additional clothing could be brought in. As a temporary measure, hospital gowns would be provided for patients to wear. We were told that the hospital did not hold a supply or stock of hospital nightwear or pyjamas for patients.

In the wards inspected, risk-based information was displayed above patient beds and was kept to a minimum to maintain patients’ privacy. Most wards also had a large whiteboard which was located away from the public. These contained relevant key information for staff. Some wards were starting to use electronic boards to display patient information. All wards were in the process of moving to using the electronic board system to support a joined-up approach and accurate patient tracking.

Multidisciplinary team working

We were told that daily board rounds, including multidisciplinary team meetings with hospital staff, took place. This allows the team to discuss care needs, evaluate and plan care. We observed these during the inspection. These allow a more co-ordinated approach to ensuring that plans of care are individualised and focused on meeting the needs of patients. Some wards had a dedicated ‘flow co-ordinator’ to support the timely transfer of patients in and out of the ward.

NHS Fife is working to improve the patients’ outcome and experience by introducing various initiatives, one of which is a dedicated hip fracture ward. This ward has 23 beds with specialist orthopaedic and geriatric input being provided by medical staff and nurse practitioners. The Scottish Government is funding this initiative over the first year and it is the first of its kind in NHSScotland. It is anticipated that having this ward in place will shorten the length of stay for patients and improve patient outcomes. Patients are transferred directly from the accident and emergency (A&E) department and will be discharged home with integrated community assessment and support service (ICASS) or move on for rehabilitation. We visited the ward during our inspection. Staff stated that it felt like there was now more staff on the ward, which allowed staff to spend more time with patients. There are strict criteria for the boarding of patients into the ward as they require beds to be available for hip fracture patients requiring admission.
Patient flow and capacity

Patient boarding is when patients are moved from one ward to another to meet the needs of the service and not the patient’s clinical needs. Following previous inspections to Victoria Hospital in May and December 2013, we had significant concerns about patient flow and capacity. From these inspections, we stated that NHS Fife must review and formally monitor patient movement within the hospital. In particular, the NHS board must monitor compliance with the standard operating procedure for patient boarding relating to moving patients with cognitive impairment for non-clinical reasons.

At the NHS board visit to NHS Fife in November 2014, we were told that patient boarding continues within the hospital due to delayed discharges. The standard operating procedure has been reviewed and, although patients with dementia can still be moved, it states that patients with delirium or distressed behaviour would not be boarded. We were told that patients with dementia would only be boarded once and procedures are in place for moving patients. We were told that there are whiteboard rounds every morning to identify which patients can be boarded. Clinical nurse managers visit the wards to review information and look at patient boarding incidents. We were told that the boarding of patients is now more risk assessed. Some wards also have a member of staff dedicated to be a ‘flow co-ordinator’ for the shift, to support patient flow and transfer in and out of the ward.

During this inspection, we found that the problem of capacity and flow within the hospital remains. This has resulted in ward 6 being opened for short-stay winter capacity and four extra beds being opened in ward 15. Additional staffing in ward 15 is being provided by agency and bank staff. These are members of staff who work as and when required depending on where the need is.

We were told that all wards are required to identify two patients to board every day to create capacity. However, some senior charge nurses told us that they have requested a revised hospital boarding policy as the current policy is not being used appropriately, or followed, due to the need for beds. It is usually the ward consultant who will identify who is suitable for boarding. However, some staff told us that, while this is adhered to during weekdays when the senior charge nurse is on duty, staff nurses on duty on night shift and over weekends feel under undue pressure to move patients who are not identified as suitable to be boarded.

During the inspection, we found the following examples.

- Patient boarding still happens out of hours and not within the boarding criteria.
- In ward 6 (a surge capacity ward), there were patients who had been in the ward for 2 weeks and did not have a clear plan for discharge as they were waiting on a bed in another hospital setting. Patients who are transferred to this ward should be expected to be discharged within 48 hours of transfer. It was noted that staff from the discharge hub visited the ward daily to review patients and explore all discharge options, including if the discharge pathway was still appropriate to meet the needs of the patient.

Following our previous inspections, we found that NHS Fife continues to board patients. However, unlike previous inspections, this is being carried out in a more co-ordinated manner. As a result, it is no longer putting patients at significant risk.

Patient and relative comments

Through our patient surveys and patient interviews, patients had the opportunity to give us their opinion about the care they received. Overall, patients were complimentary about the care and treatment they had received from all members of staff. However, some relatives raised concerns. Most patients said they were included in conversations about their
treatment and that questions were answered in terms they understood. Patients also stated that staff introduced themselves and were compassionate and considerate.

Of the 30 patients who completed our questionnaire:

- 26 stated they had been given clear information about their condition and treatment
- 29 stated the quality of care they received was good, and
- 23 stated that they felt involved in their care.

Through our carer and visitor questionnaires, family members, carers and friends had the opportunity to give us their opinion of the hospital. Of the 18 people who completed our questionnaire:

- 16 stated that ‘Staff have taken the time to get to know the person I am visiting’, and
- 18 stated that ‘The quality of care the person I am visiting receives is very good’.

We received positive comments from patients through our surveys and interviews.

- ‘I have found the staff very helpful and considerate and prepared to take time to explain situations and reasons for action taken.’
- ‘I have been treated in a very professional manner. The doctors discuss my care with my husband and we are involved in my care. All the nursing team are excellent, and I cannot praise them too highly.’
- ‘Staff, doctors, nurses and care staff are more than happy to oblige and discuss any issues I have as to my care and wellbeing. Cleanliness and procedures at meal times are strictly adhered to. I was made to feel, and am feeling, confident and reassured in the care I am being given.’
- ‘I have found the staff very helpful and considerate and prepared to take the time to explain situations and reasons for action taken.’
- ‘When admitted, I didn’t wait long to be seen. The staff were really good, kind and caring, making my stay a lot easier for me and my relatives.’
- ‘The staff looked after me like I was one of their family.’

Some patients and relatives told us of some concerns and worries they had.

- ‘Certain issues occur on a regular basis when you are first in admissions. These need to be addressed and rectified. This would go a long way with patient relationships going forward.’
- ‘[I was] waiting for more than one hour for someone to come back, having asked 3 times to re-start my father’s intravenous (IV). Due to age of patient and raised urea, he is classed as high risk and requiring admission for IV fluids. It is 1.5 hours since the IV was inserted, then stopped. We are still waiting for it to be checked/re started.’
- ‘I have made a formal complaint about [a ward] where my dad was previously as he developed a deep pressure sore while there, which was not advised to me. My dad is due to be moved into a community hospital. I do find that process stressful as no notice is given other than a phone call to say ‘patient on way to ?’. When you are dealing with elderly and confused patients then more consideration should be taken.’
- ‘My wife requires assistance at present to be taken to the toilet. She thinks staff sometimes take some time to respond to the buzzer.’
• ‘[In one ward] a doctor completely ignored me, simply continued working on the notes/computer he was working on . . . staff have answered any questions and appear more receptive. [The ward] seemed very short staffed. My wife was admitted before midnight. A nurse came some time later and asked me to wait after answering some questions. She said she would be back in 30 mins as they were short staffed. She eventually arrived much later, very apologetic and it was 3am before she finished questioning me.’

Patient and staff interactions
We used a formal observation tool in all wards inspected to observe interactions between staff and patients. The majority of interactions with patients were positive and caring. We found that staff were supportive, and talked to patients in a respectful manner. We heard staff introduce themselves to patients and check that they were comfortable.

Although there were no inappropriate interactions with patients, we heard two separate instances of staff referring to patients by their room or bed number, as opposed to their name. This was brought to the attention of the nurse in charge of each ward.

Patient and carer involvement
Staff in ward 15 have participated in training provided by the Alzheimer Scotland professional development nurse. They also plan to introduce the ‘partners in care scheme’ which is currently in place in ward 12. This is a proactive approach to encourage family and/or carer involvement whilst the patient is in hospital. The involvement is only where it is indicated that the family and/or carer wish to be involved and for the activities agreed within the plan of care. Involvement can be reviewed at any time during the patient’s stay to ensure that the family and/or carer’s needs are also met.

Care rounding
Care rounding is in place within Victoria Hospital. This is where staff actively check patients at pre-determined intervals. From the patient health records reviewed, we found that, although the frequency of care rounding was prescribed daily, this was not always implemented. Therefore, it was unclear how the patient knew how often someone would be back to check on them. Where frequencies were recorded, we saw a number of gaps.

Areas of good practice

■ A dedicated ‘flow co-ordinator’ and whiteboard rounds have been put in place. This supports patient flow and transfer in and out of the ward.
■ A dedicated hip fracture ward is in place. It is anticipated that having this ward in place will improve patient outcomes and result in a shortened length of stay for patients.

Area for improvement

1. NHS Fife should continue to review and formally monitor patient movement within Victoria Hospital. In particular, the NHS board must monitor compliance with the standard operating procedure for boarding relating to moving patients with cognitive impairment for non-clinical reasons.
3.2 Screening and initial assessment

**Outcome 1:**
The patient is supported to return home (or to a homely setting or care service) or if necessary admitted directly to the correct ward (in this or other appropriate hospital).

Ensuring older people are screened and assessed appropriately on arrival at hospital, including medicines reconciliation. Where initial assessment and screening identifies care needs, a multidisciplinary team completes a detailed assessment without delay. Once the assessments are completed, admission or discharge occurs promptly.

Since our previous inspections, NHS Fife has implemented the ‘Perfect 10’ audit tool. This contains a set of 10 questions for food, fluid and nutrition, pressure area care and cognitive impairment. The senior charge nurse reviews five patient health records each week. This can then be used to show how a ward is performing with results being reviewed by the inspection co-ordinating group.

NHS Fife’s self-assessment states that there are various pathways in use in Victoria Hospital as an alternative to admission to hospital. This includes the use of the hospital at home service. Hospital at home can be an alternative to hospital admission for appropriate patients where a team of doctors, nurses and allied health professionals visit the patients at home to deliver care and treatment.

Frailty screening is being carried out on all admissions into the admissions unit. Where further assessment is indicated, frailty assessments which include the 4AT are being carried out by the integrated assessment team. This team includes nurses, physiotherapists and occupational therapists. Completion of the assessment ensures that care needs are identified and will then determine which pathway the patient follows. It can prompt referral to the medicine for the elderly team and identifies the most appropriate patients for admission to one of the care of the elderly medical wards.

**Dementia and cognitive impairment**

NHS Fife’s self-assessment states that a mandatory part of the electronic record for patients, presenting at A&E, is cognitive assessment using the AMT4 cognitive assessment tool. However, the 4AT cognitive assessment tool is used for patients with a hip fracture, as this will enable early identification of delirium in this vulnerable group. Patients with a confirmed hip fracture are now admitted directly to the specialist hip fracture ward from A&E. For other patients admitted, there are various prompts for cognitive assessment within the patient health record and assessments, such as, falls and frailty.

Of the 33 patient health records reviewed for dementia and cognitive impairment, 29 had a completed cognitive assessment using either AMT4 or 4AT. This is a significant improvement since previous inspections to Victoria Hospital. Of the remaining four patient health records reviewed, one patient was identified as having a possible cognitive impairment, but it was not clear what investigation or referral had taken place, despite NHS Fife having pathways in place for cognitive impairment and delirium.

From the patient health records reviewed, we noted the following.

- Input from the occupational therapist requesting an AMT assessment for a patient. This patient was also noted to be ‘agitated, confused and unsettled’ on various occasions, but no care plan or further actions were seen to manage this behaviour.
Where the AMT4 was used for initial cognitive assessment, if a patient did not score fully, then there was no further action or evidence taken if the patient was noted as being ‘confused’ or ‘agitated’.

In one patient health record, a sticker was present and ‘delirium pathway’ was ticked on it. The staff nurse spoken with could not tell what this meant and there was no evidence of a ‘delirium pathway’ in use for this patient.

**Nutritional care and hydration**

Nutritional screening is carried out using the Malnutrition Universal Screening Tool (MUST). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. During the inspection, we reviewed 33 patient health records for nutritional care. Of these, we found that 15 MUSTs had been carried out within 24 hours of admission.

We found that two different versions of the MUST document were in use. This is as a result of a phased move to new MUST documentation, reflecting changes from the recommendations of our previous inspection.

During the inspection, we found the following.

- Eighteen patients did not have a MUST completed within 24 hours of admission. One patient did not have a MUST completed until 5 days after admission. It was recorded that this had happened as the patient was unable to be weighed. No estimated MUST had been carried out until such times as the weight could be obtained.
- One patient’s MUST was not completed until 9 days after admission. The score indicated that the patient was at high risk of malnutrition and was referred to the dietitian.
- Another patient had no body mass index (BMI) entered in the patient health record and a further three repeat screenings had the wrong BMI recorded. The BMI is a measure of relative weight based on an individual's mass and height. An accurate BMI is needed to calculate the MUST score. It was not always clear how the MUST score had been calculated as not all elements of the assessment were entered to count towards the final score.
- In one patient health record, we saw that the ward dietitian had requested that the patient’s weight be taken on six separate occasions. This had not been carried out by nursing or dietetic staff at the time of inspection. This patient was receiving artificial nutrition and their weight forms part of an accurate assessment to ensure they are receiving the correct amount of nutrition. This patient had been admitted 14 days previously and had not been weighed or had a MUST completed.

During the inspection, we found an inconsistent approach to rescreening. If rescreening is carried out, it would highlight any changes in the patients’ nutritional needs. We found the following examples.

- One patient had a rescreening of MUST completed which indicated that they were at high risk of malnutrition. Although this had been identified on the initial screening, a referral had not been made to the dietitian. This was picked up at the time of rescreening and the dietitian was contacted for further assessment of the patient.
- Another patient was assessed as being at no risk of malnutrition. There was no rescreening carried out despite the dietitian assessing the patient as being at high risk due to weight loss. There were entries by the dietitian requesting that an accurate weight be obtained.
- One patient did not have a MUST completed until 24 days after admission to hospital. Although the patient was not identified as being at risk of malnutrition, the lack of weekly
rescreening meant that the weight was not measured to allow accurate calculation of any weight loss.

**Nutritional assessment**

We saw that the patient health record contained a nutritional profile. This document details any special dietary requirements, religious or cultural dietary needs, likes or dislikes or any assistance the patient needed.

**Falls assessment**

During the inspection, we reviewed 31 patient health records for falls. All patient health records had a falls assessment in place. We saw two different falls assessments were in use in the hospital, which we were told is due to testing of the new falls bundle of care and associated new documentation. However, whilst the assessment had prompted a care plan to be initiated, it was not always evident that a more detailed multidisciplinary assessment had been carried out, for example the review of medications that can lead to falls or other medical causes. Where the frailty assessment had been carried out, it did prompt the falls pathway to be completed.

**Preventing and managing pressure ulcers**

NHS Fife use the pressure ulcer risk assessment (PURA) as the risk assessment for identifying risk of pressure ulcer damage. We were told that the decision not to use a more detailed pressure ulcer risk assessment was made to reduce the documentation burden on nursing staff. The PURA tool asks four questions which relate to the patient’s mobility, continence, nutrition and skin. NHS Fife’s self-assessment states that a PURA is carried out within 6 hours of admission to hospital, and within 6 hours of transfer to a new ward area. It is carried out on a daily basis thereafter and any skin integrity concerns are to be recorded on the ‘pressure ulcer record’ on the back of the PURA sheet. Where a risk is identified, a SSKIN (skin, surface, keep moving, incontinence, nutrition) bundle is commenced.

During the inspection, we reviewed 33 patient health records for pressure area care and found that 30 patients had a PURA completed within 6 hours of admission. This is a significant improvement since previous inspections to Victoria Hospital. The remaining patient health record did have a PURA completed, but as it did not state the time the patient was admitted, we could not establish if it was completed within the recommended timeframe. The majority of patient health records showed evidence of ongoing daily reassessment using the PURA tool.

**Medicines reconciliation**

The Chief Medical Officer (CMO) (2013) states that, when a patient is admitted to hospital for more than 24 hours, medicines reconciliation should take place. This should include a documented record of the patient’s details and whether they have any allergies. Any medicines prescribed to the patient should only be listed after checking with two or more sources. This can be the patient, a carer, GP, pharmacy or a printed GP letter. There should also be a medicines plan for each medicine to indicate if the medication is to ‘continue’, ‘stop’ or ‘be withheld’. It should be clear who has completed the form and there should also be evidence of a pharmacist review.

Medicines reconciliation documentation is included within the patient health records used in the medical wards. However, the surgical documentation does not include a medicines reconciliation page. We were told that the doctors would document the medication that the patient was taking on admission.
During the inspection, we reviewed 34 patient health records for medicines reconciliation and found that 30 patients had this document in place. However, we noted:

- some had no documented plan in place, despite the form containing a table to complete if the medicine was to continue, be stopped or withheld
- some had gaps in recording, for example allergy sections were blank
- one had no patient demographics and no signature of who completed the form
- one had no patient demographics, plan to continue or stop medication or pharmacist signature, and
- another four had no pharmacist signature.

**Do not attempt cardiopulmonary resuscitation**

Do not attempt cardiopulmonary resuscitation (DNACPR) relates to the emergency treatment given when a patient’s heart stops or they stop breathing. Sometimes medical staff will make a decision that they will not attempt to resuscitate a patient. This is because they are as sure as they can be that resuscitation will not benefit the patient. For example, this could be when a patient has an underlying disease or condition and death is expected.

When this decision is made, opportunities should be taken to have honest and open communication to ensure patients and their families are made aware of the patient’s condition. However, in some cases, clinical staff may decide not to share this information as they feel it may cause too much distress for the patient and their families. This decision should be clearly documented in the patient notes.

Following our previous inspections, NHS Fife was required to ensure that clinical staff consistently comply with the national policy on DNACPR. During the NHS board visit to NHS Fife in November 2014, we were told that the resuscitation team now carry out audits and leave a note in the patient health record when the forms are incorrect. This allows learning by the medical team completing the forms in addition to the training sessions provided. We were told that there is now 100% compliance with expected deaths having a DNACPR form in place.

During the inspection, we reviewed 10 DNACPR forms and found that eight had been fully completed. This is a significant improvement since previous inspections to Victoria Hospital. We saw that the patient health record used in the admissions unit contains a prompt to record if a patient is to be resuscitated or not. This was completed in all records viewed documenting a clear decision about DNACPR status.

**Documentation**

We found that some wards are using a functional assessment relating to patient’s activities of daily living. This assessment identifies what assistance or aids a patient may require with activities, such as washing and dressing, communicating, toileting and mobility. If this assessment is not fully completed, it does not inform care planning or provide assurance that all the individual’s care needs will be met.

In two wards, we saw a combined notes folder for patients which contained medical, nursing and AHP documentation for the current admission. We were told that this saved time for staff and worked well in practice, as all relevant information was easily located. However, in other wards the documentation was not as streamlined.
During the inspection, we found different versions of assessments and care plans in use within the same ward and, on occasion, within the same patient health record. There is an inconsistency in relation to what documentation should be used for what patient.

Medical and nursing documentation was not always dated and timed. In some patient health records, we found pages which did not have the patient name or any other identifier. In one ward, the pages of the documentation booklet had been separated and there was no space to record the patient’s details. This could result in pages being lost or filed in the wrong patient health record. For example, a MUST care plan was noted to have been put in place by the dietitian who had written the entry, but the care plan did not state the patient’s name or any other detail.

In some wards, we saw that a typed, comprehensive SBAR (situation, background, assessment, recommendation) ward handover sheet was being used during staff shift handovers. This contained relevant and risk-based patient information and was disseminated to all ward staff. However, in other wards, nursing staff were still using handwritten pieces of paper to take notes during handover.

Areas of good practice

■ Frailty assessments are being carried out by the integrated assessment team. This ensures that care needs are identified and will determine which pathway the patient follows.

■ A comprehensive SBAR handover sheet is used to outline relevant and risk-based information to staff.

Areas for improvement

2. NHS Fife must ensure that nutritional screening is carried out for all patients within 24 hours of admission. Nutritional rescreening must also be carried out weekly, or according to patient condition.

3. NHS Fife should ensure that documentation is standardised throughout the hospital and a consistent approach is applied.

3.3 Person-centred care planning

Outcome 2:
The patient (and their carer, if appropriate) is consulted and involved in decisions about their care.

Ensuring that all care is person-centred and that care plans are developed with the involvement of the patient and their carer, if appropriate.

During the inspection, we saw little evidence of personalised care plans. Although we saw some evaluations of care within the patient health records, it was unclear what was being evaluated as there were only falls and MUST care plans in place. Following the initial and ongoing assessments, no other care plans were created to outline the specific care or treatment needed for each patient. This is especially important in specialist wards, for example a stroke ward where patients have multiple needs. This can include mobility, oral hygiene, continence, pain or communication needs. No care plans were seen to meet any of these needs or guide staff on the ward, including student nurses or bank staff.
During the inspection, when reviewing the patient health records, we found the following.

- Some falls care plans had been circled to individualise certain interventions, but not all.
- Although the appropriate level of care plans were in place for nutritional care, some were blank and had not been written on.
- None of the ward documentation clearly demonstrated the care that an individual required to meet their personal care needs. There was no documented evidence that the patient and/or relative had been involved in care planning or that patients had consented to the proposed plan of care. This could make it difficult for bank staff or staff from another area of the hospital to know what care was required.
- SSKIN bundles were in place as part of the active patient care record. However, this is not a care plan for the prevention and management of pressure ulcers. Although there was evidence in SSKIN bundles of patients having their skin assessed and having their position changed, this was not demonstrated through care planning.
- No care plan was in place for a patient with cognitive impairment who was documented as being distressed and hallucinating. Therefore, it was unclear what measures staff had identified to reduce or manage the distress being experienced by the patient.
- One patient with dementia was documented as having behavioural issues. However, no care plan was in place for how to manage the behaviour or other impacting factors.

**Area for improvement**

4. NHS Fife must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patient’s condition or needs.

### 3.4 Safe and effective care

**Outcome 5:**
The patient, with dementia (or cognitive impairment), experiences care that is tailored to meet their individual needs and promotes their mental wellbeing.

**Ensuring that:**
- care for older people with dementia (or cognitive impairment) meets the Scottish Government Standards of Care for Dementia in Scotland, and
- guidelines on use of medication for the behavioural and psychological symptoms of people with dementia and/or delirium are available to all staff.

**Delirium**

At the time of the inspection, the Alzheimer Scotland professional development nurse and the consultant nurses for older people were in AMAU to test a new process, educate staff and measure improvement within the admission unit in relation to delirium as part of delirium awareness week. This week was a test and the foundation for spread of enhanced delirium care throughout acute care, using the Healthcare Improvement Scotland ‘Think Delirium’ toolkit. Staff were also introducing the TIME (thinks, investigate, management, engage and explore) bundle. This is an evidence based care bundle to deliver systematic care to the person with delirium.

NHS Fife has a delirium pathway in place to guide the care and treatment of patients with delirium. This includes advice on referral to specialist services, the use of medication for...
stressed and distressed behaviour, and a clear prompt to assess capacity to consent to treatment.

**Adults with incapacity**

The Adults with incapacity (AWI) Section 47 certificate is used to authorise treatment for patients who are unable to consent to treatment themselves. When people who have lost the capacity to make decisions about their welfare are admitted to hospital, it is important to know if they have an appointed power of attorney or guardian. This is someone who is appointed to make decisions on another person’s behalf when they are unable to do so themselves.

NHS Fife’s self-assessment states that an AWI audit was carried out in March 2014. The audit found that the completion of the AWI Section 47 certificate and treatment plans remained inconsistent. Following this, a new package of documentation, which combines the Section 47 certificate, treatment plan and assessment of capacity, had been implemented. The AWI document contains a prompt to establish if a power of attorney is held. This demonstrates consideration of the principles of the AWI Act in recognising the rights of alternative decision makers. We were told that this has supported improvements in complying with the AWI legislation.

For the four AWI certificates reviewed during the inspection, all had been fully completed and had a documented assessment of capacity to consent to treatment. However, the accompanying treatment plans were not always well completed to reflect all the proposed interventions and were not signed as being discussed with the patients’ families. The treatment plans contain some pre-printed entries for fundamental care needs and the management of pre-existing medical conditions. There is limited space to record additional individual needs. NHS Fife has recognised this through its revised audit of compliance and is seeking ways to improve, including revising the space available on the treatment plan to record all interventions.

**Environment for people with dementia and cognitive impairment**

NHS Fife’s self-assessment states that refurbishment works have been carried out at Victoria Hospital and further development is planned. The Alzheimer Scotland professional development nurse has been involved in the current refurbishment works. This person has the opportunity to influence the design of the works being carried out, for example the flooring type, lighting, signage and colouring of surfaces. People with dementia or cognitive impairments can benefit from environments that are adapted to limit potential confusion and distress.

The self-assessment also states that dementia design environmental audits have been carried out. The reports from these audits are given to the estates department for inclusion in the design process for future ward refurbishment projects and minor improvement works.

During the inspection, we saw that the majority of wards had made changes to improve the environment for patients with dementia. The wards had different layouts and designs depending on if they were situated in the older or newer part of the hospital. All wards had contrasting grey grab rails along the walls. Most patient areas had large wall clocks and dementia-friendly signage to indicate where the ward toilet or showers were located.

Since our previous inspection, ward 15 has undergone significant renovation. There is good use of colour contrasting and dementia-friendly signage. The ward’s sitting room area was being furnished to provide the opportunity for reminisce. An activity box for patients to use was available in this area. We were told that ward and estates staff have visited the Stirling Dementia Centre to look at the best design principles for dementia care before the
renovation work was carried out. The principles will be taken into account for any future plans of work.

**Meaningful activity**

NHS Fife’s self-assessment states that activity boxes have been provided in all wards. An audit has been carried out to find out how often the boxes are used. The outcome of this audit will inform an evaluation plan. The hospital is also looking at how volunteers can help with the boxes. During the inspection we saw that these boxes were in place.

We saw that some wards had also introduced a ‘Tea for two’ service. This is when volunteers come into the wards and sit with a patient. The aim is to encourage meaningful interaction to promote self-esteem whilst having a cup of tea and cake.

We were told that NHS Fife is part of a research project, with Glasgow Caledonian University, to determine the benefit of using ‘Playlist for Life’ within an acute hospital setting. This is a project which encourages families and caregivers of a person with dementia to create a playlist of unique and meaningful music on an iPod and offer it at any time of the day or night. It can be used in a range of settings and there is evidence it can improve mood, awareness, ability to understand and think about sense of identity and independence. This project will take place in the medicine of the elderly wards.

**Dementia champions**

NHS Fife’s self-assessment states that a development day for dementia champions was held in January 2014. The aim of this was to outline the strategic direction for dementia care (locally and nationally), identify local activity, agree improvement needs, agree a collaborative and individual work plan and establish a format for dementia champion network meetings. The dementia champions are given protected time to attend these meetings.

We were told that dementia champions share progress reports with managers three times a year. The work plan includes support to embed the ‘Getting to know me’ document and environmental audit, as well as a locally identified action. All wards inspected had posters on display stating who the dementia champions for the ward are.

**Psychiatric liaison service**

Victoria Hospital has a psychiatric liaison service for older people which provides advice, support and consultation to staff. Staff stated that they could easily access the psychiatric liaison team, if required. During the NHS board visit to NHS Fife in November 2014, the psychiatric liaison nurse told us that the referrals to the team are now more appropriate which demonstrates that interventions for delirium and dementia have taken place at a much earlier stage.

We saw that information leaflets were available for patients and relatives on a range of topics covering memory loss, delirium and dementia. They included information on sources of support for patients and carers. There were also posters on display promoting the ‘Getting to know me’ document.

**Areas of good practice**

- AWI certificates were well completed and had a documented assessment of capacity to consent to treatment.
- The dementia design principles were taken into account when refurbishing wards. This will also be considered for future ward refurbishment projects and minor improvement works.
Areas for improvement

5. NHS Fife should continue to develop and rollout delirium improvement work within Victoria Hospital.

6. NHS Fife should ensure that assessment of capacity treatment plans are in place to reflect proposed interventions and these are documented as being discussed with the patients’ families.

Outcome 6:
The patient’s status is maintained or improved and appropriate food, fluid and nutrition is provided in a way that meets their individual needs.

Ensuring care for older people meets the NHS Quality Improvement Scotland Clinical Standards for Food, Fluid and Nutritional Care in Hospital.

Patient weighing equipment

All wards stated that they had access to a range of patient weighing scales and equipment, for example hoist scales, chair scales or stand on scales. Accurate weights are required for the safe and effective prescribing of medications and to monitor any weight loss.

In one patient health record, we saw that the patient had been prescribed IV antibiotics, one day after admission, based on a patient’s recorded weight of 72.7kgs. However, the first actual weight recorded for this patient was 10 days later. This recording was different to the weight used for the prescription. It was unclear how this initial weight was obtained as it was not used to complete the MUST and it was not found within the patient health record.

Complex nutritional care management

During the inspection, we discussed the management of patients with swallowing difficulties with a senior charge nurse. We were told that nurses in the stroke ward are using the starter regime to commence patients on artificial nutrition, if required. The senior charge nurse also confirmed that there have been very few issues in the reporting of chest X-rays to confirm the placement of nasogastric (NG) tubes. This is an improvement since our previous inspection.

The senior charge nurse also discussed the skill mix of staff on duty and education and training undertaken by nurses for complex nutritional care. This is to ensure that ward staff are skilled and competent to care for stroke patients and carry out procedures, such as water swallow testing and passing NG tubes for patients, if required. Staff also need to be able to safely assess individual patients and ensure that they are well enough and able to be in a safe position before passing an NG tube.

During the inspection, we found the following.

- In one ward, we saw that a patient receiving artificial nutrition had their hourly check chart fully completed by nursing staff.
- In another ward, the amount of artificial nutrition which the patient had received was not documented on an artificial nutrition chart or fluid balance chart, instead it was written freehand in the patient health record. This means that it would be difficult to find out how much had been taken on previous days. It was also recorded that ‘regular oral hygiene was given’ as the patient was nil by mouth. However, there was no care plan to indicate how often the patient needed or wanted oral care or what was being used to inform care delivery and guide the wide range of staff.
Another patient health record showed clear documented evidence of the discussion of options for the patient where there was difficulty in passing an NG tube. Clear plans, actions taken and updates were all well documented by medical staff.

Management and provision of nutrition and hydration

Each ward had a nutrition board which detailed special diets or patients requiring assistance. This information was also communicated on the ward handover sheet. Patients who were nil by mouth were also highlighted in the ward safety brief. From the patient health records reviewed, we saw very good dietetic input documented, with clear advice and guidance provided for staff to follow.

Protected mealtimes

We found that mealtimes were generally well managed and organised, with most of the ward staff being involved in the serving of meals. The majority of patients were prepared or appropriately positioned for eating and drinking before their meal arrived. Patients were not routinely offered the opportunity to wash their hands before their meal. Meals were given out in a timely manner to ensure the correct temperature and patients were given appropriate assistance, where required. All wards also had access to adaptive equipment.

During the inspection, we saw that protected mealtimes were in place to reduce non-essential interruptions during mealtimes. This is to ensure that eating and drinking are the focus for patients without unnecessary distractions. We saw posters on display to explain protected mealtimes and to indicate when meals would be served.

Menu and provision of snacks

Victoria Hospital has a wide range of menus available for patients to meet their dietary needs. A ‘finger foods’ menu is also available, which contains smaller snack-type foods. This can be useful for patients who only want a small snack or for patients who find it easier to eat with their hands. We were told that any patient can order from this menu and this can be offered as an alternative to the normal menu.

All wards inspected had good supplies of basic provisions including bread, cheese, breakfast cereals, yoghurts and diluting juice. The care of the elderly wards also had sandwiches delivered to offer to patients in the evening. We were told that wards also routinely give patients tea and toast during the evening.

There is a good working relationship between wards and catering staff. Ward staff told us that the hospital kitchen is flexible and accommodating when asked to provide an alternative meal for a patient if they do not like what is offered on the menu. Hot meals can also be prepared for patients who are admitted to a ward after mealtimes.

In ward 6, staff told us that patients are only given a choice of whatever meals have been sent up from the kitchens, as opposed to ordering their meals the day before. Patients in this ward do not get a hot meal for lunch and are instead offered soup and sandwiches. We were told that this is due to the ward being a short-stay winter capacity ward where patients are expected to be discharged home within 48 hours of transfer. However, at the time of the inspection, some patients had been in this ward for 2 weeks.

Food and fluid charts

Food and fluid balance charts are used to record how much patients are eating and drinking when there are concerns about their intake and output. These charts may be requested by medical staff, dietitians, speech and language therapists or started by nursing staff.
During the NHS board visit to NHS Fife in November 2014, we were told about the developments and improvements being made to patients’ fluid management. NHS Fife has a consultant who has the role of ‘fluid lead’. There was previously a ‘fluid nurse’ in post to support good practice, including the completion of fluid balance charts. However, at the time of our inspection, this post was vacant.

A new fluid management document has been created which is a combined fluid prescription and fluid balance chart. The chart should be totalled at 2pm to consider if the patient has had a minimum of 500mls of fluid intake. Where intake is less, there is a prompt for further action. The document will be rolled out across all adult inpatient areas, with the exception of critical care. This standardised document has allowed unification of start and stop times for fluid balance charts, thereby contributing to improvement in transitions in care. Other developments include a ‘criteria for fluid balance chart use’ however, we did not see evidence of this in all the wards visited.

During the inspection, we found that the completion of fluid balance charts was generally poor. From the charts reviewed, we noted that inputs and outputs were not fully recorded and, where these levels were low, there was no documented action taken. Totals and balances were not calculated or documented and no fluid goals had been written. There was also no record of the previous day’s fluid balance to inform staff how to treat the patient the next day.

During the inspection, when reviewing the fluid balance charts, we found the following.

- One patient had two fluid balance charts in place for the same day. On 15 February, no fluid intake had been recorded after 8am and only 400mls total had been recorded for the entire day and night. On 16 February 2015, no fluid intake had been recorded after 12noon and only 470mls had been recorded for the entire day and night.
- Another patient only had 100mls of fluids documented as being consumed for that day (before 4pm). On the previous day, the recordings on the fluid balance chart and food record chart did not match, as different amounts were recorded for the same day. These charts had not been totalled, there were no balances or fluid goals stated and there had been no carry forward to the next day.
- The patient health record for one patient showed that the patient’s relatives had voiced concerns about the incomplete fluid charts and poor nutritional intake. On one day, this patient was documented as only having 570mls to drink and had no recorded amount of urine output.

During the inspection, we also found that the completion of food record charts was variable, with some showing that no record of intake had been taken over all mealtimes. Some charts did not state the type of food offered to the patient. Therefore, it would be difficult for a dietitian to be able to assess what each patient had actually eaten and ascertain if they were meeting their nutritional needs or not. We also found that there were two versions of the food record chart in use in the hospital.

During the inspection, when reviewing the food record charts, we found the following.

- We saw two food record charts in place for a patient for the same day. However, different amounts had been recorded for the same patient at the same mealtime. We saw that ‘1/4 porridge, 100mls tea’ had been recorded on one chart and ‘all porridge’ on the other. This demonstrates inaccurate recording and an unco-ordinated approach to recording patients’ intake.
In another food record chart, we saw that ‘strict food chart please’ had been recorded for a patient who was diabetic. However, some of the amounts the patient had eaten had not been documented. In another entry, ‘1/4 of lunch’ was all that was documented for the entire day. Yet in the patient health record for this patient, the staff nurse had written ‘good nutritional intake noted’.

**Area of good practice**

- There is a good relationship between ward staff and catering staff. There is also flexibility in meeting patients’ dietary preferences.

**Area for improvement**

- NHS Fife must ensure that food and fluid balance charts are commenced and accurately completed for patients who require them and appropriate action is taken in relation to intake or output, as required.

**Outcome 7:**

Where avoidable, the patient does not fall during their stay in hospital.

Ensuring a systematic process is in place to assess older people for the risk of falling (which includes medication review) and individualised controls are implemented to prevent falls or reduce any risk to a minimum.

NHS Fife’s self-assessment states that falls prevention is a strategic priority and there is a significant drive to improve the incidents of falls across the whole organisation. A frailty screening tool is completed on admission for all patients, which includes falls screening questions.

NHS Fife recognises that there is a lot of work still to be carried out on falls prevention and improvement initiatives have been put in place. A safety bundle is currently being piloted which will provide appropriate, person-centred care, including the initiation of comfort rounding. We were also told that a falls improvement day has recently been held to raise staff awareness.

Patients, who are identified as being at risk of falls, are identified during the ward handover and the ward safety brief. We saw that falls safety crosses were on display in all wards inspected. All wards also have access to high/low beds and chair alarms for patients. We saw these in use during the inspection.

**Outcome 8:**

Where avoidable, the patient does not acquire a pressure ulcer during their stay in hospital. If they are admitted with a pressure ulcer their care is tailored to their needs.

Ensuring care for older people is delivered in line with the NHS Quality Improvement Scotland Best Practice Statement for the Prevention and Management of Pressure Ulcers, so patients can be identified as being at risk of a pressure ulcer and receive care to minimise the risk, including access to a local wound care formulary.

NHS Fife’s self-assessment states that a PURA is carried out within 6 hours of admission to hospital, and within 6 hours of transfer to a new ward area. It is carried out on a daily basis thereafter and any skin integrity concerns are to be recorded on the ‘pressure ulcer record’ on the back of the PURA sheet. Where a risk is identified, a SSKIN bundle is commenced.
During the inspection, when reviewing the patient health records, we found the following.

- **SSKIN bundles were not always initiated when an issue was identified on the PURA.** For example, one patient was identified as having a nutritional deficit and was receiving input from the dietitian. The SSKIN bundle was not triggered until the patient became incontinent and required more frequent interventions.

- **Some SSKIN bundles stated the mattress type that the patient was on, but others were blank.** Therefore, it was unclear if the patient was on the appropriate surface as there were no care plans to state what surface the patient needed.

- **Some SSKIN bundles were not fully completed to accurately inform care.** For example, the frequency of planned intervention was not always stated or signed by the registered nurse initiating it. Where frequencies were documented, many SSKIN bundles had long gaps where care should have been delivered.

**Specialist pressure relieving equipment**

NHS Fife’s self-assessment states that pressure relieving equipment stores are located in Victoria Hospital which are accessible 24 hours a day. Staff can request pressure redistributing equipment by telephone, through portering staff or through the out-of-hour’s duty co-ordinator. During the inspection, we saw that pressure relieving cushions and mattresses were in use and staff knew how to obtain these.

**Tissue viability service**

NHS Fife has a tissue viability service which can be accessed through telephone referral. All wards inspected had tissue viability link nurses in place. During the NHS board visit to NHS Fife in November 2014, we were told that study days for link nurses are carried out 2–3 times a year. The topics covered within these study days, include faecal management systems, moisture lesions and bariatric equipment. The link nurses stated that they have no problem attending these study days or tissue viability meetings and are supported by their senior charge nurse. They also felt that that they were well used as a resource and are provided with a role clarification document which outlines what is expected of them.

Each ward has a tissue viability resource folder for staff to access information about pressure area care and wounds. It is the tissue viability link nurse’s responsibility to keep the folder up to date.

**Pressure ulcers and wounds**

During the inspection, when reviewing the patient health records, we found the following.

- **In one ward, a patient had two pressure ulcers.** Although these were not acquired in hospital, there was no wound assessment chart to show how the wound was healing. The patient had been referred to the tissue viability nurse and the type of dressings required had been documented. However, there was no record of how often the dressings were to be changed or how often the wound should be reviewed.

- **In another ward, we reviewed the care of a patient who had multiple wounds.** Wound charts and patient health record clearly evidenced the plan of care, including referral to the tissue viability service. We could see that there was ongoing evaluation of care and treatment.

- **In another ward, one patient had several wounds.** There were well-completed wound charts to guide care and treatment. There was good involvement from the tissue viability team and wounds were documented as improving.
In another ward, a patient had a pressure ulcer. The patient health record stated ‘grade 2 sacral sore, dressing intact’. There was no wound chart or grading tool found in the record. When we asked the staff nurse who was looking after the patient, they were not aware that the patient had a pressure ulcer or what dressing was in use. The staff nurse looked at the handwritten handover notes and found that this information had not been passed over. This was a high risk patient, who was also nutritionally vulnerable. The SSKIN bundle for this patient also had gaps.

Area of good practice

- Tissue viability services, including tissue viability link nurses, are embedded in the hospital to support the patient’s journey.

Areas for improvement

8. NHS Fife must ensure that wound charts and any related documentation are in place for those patients with a known pressure ulcer or break in skin integrity to support safe and effective care delivery. This must include recording the severity and grade of any pressure ulcers and a clear plan of management. Documentation must be appropriately and consistently completed and be easily accessible.

9. NHS Fife must ensure that when a SSKIN bundle is implemented, a care plan is in place which identifies all the patient’s individual needs in relation to preventing and managing pressure ulcers and clearly demonstrates how those needs are to be met.

3.5 Managing the return home

Outcome 9:
The patient is able to return home (or to a homely setting or care service) as soon as they are well enough to do so. Any additional support that they require at home is in place at the time of discharge.

Ensuring that:
- older people are discharged from hospital in a planned way and without delay
- partnerships between acute care settings and community care services support a co-ordinated approach to discharge, and
- medicines are reconciled as part of the discharge process.

NHS Fife’s self-assessment states that the discharge hub was established in Victoria Hospital in August 2013. The function of the discharge hub is to maintain patient flow by facilitating effective discharge planning and co-ordination.

From the patient health records reviewed, we saw no documented evidence of routine discharge planning taking place. Discharge documentation was only being used as a discharge checklist. However, we saw evidence of complex discharges being referred to the discharge hub.

During the inspection of ward 6, we saw staff from the discharge hub visit the ward for the ‘daily whiteboard update’. This update allows care needs and discharge plans to be co-
ordinated, which leads to prompt discharge. The discharge hub was able to ensure that the correct discharge pathway was being followed to meet the patient’s needs. For example, one patient had been waiting for a rehabilitation bed in another hospital. However, due to the lengthy waiting list, services were put in place to allow the patient to be discharged home.

Area for improvement

10. NHS Fife should ensure that any decisions made about discharge planning are clearly recorded on the discharge documentation.

3.6 Leadership and accountability

Outcome 10:
The patient is cared for by staff who are knowledgeable, competent and accountable for the care they deliver.

A clinical and care governance framework is in place which will underpin the quality improvement agenda and safeguard high standards of care. Staff are aware of relevant legislation, national standards and key strategies which support this framework.

NHS Fife’s self-assessment states that there is a range of training available to different levels of staff. This includes a variety of topics delivered in a range of formats. Learning is shared through the link nurses and dementia champions within the wards.

Senior charge nurses monitor compliance of nursing documentation through use of the ‘Perfect 10’. This is a local audit tool which was developed to capture data on a weekly basis for cognitive impairment, food fluid and nutrition and pressure ulcer care. Senior charge nurses discuss the findings from the audits during the ward safety briefs. The heads of nursing then report back on the audits, both improvements and challenges, to the fortnightly inspection co-ordinating group.

Outcome 11:
The patient is cared for by staff who are led and supported by effective managers and leadership at every level (from line manager to executive team and NHS Board members).

The NHS board is able to demonstrate that there is strong leadership from the Board downwards throughout the whole organisation. The management structure of the NHS board can be clearly articulated and evidence is available to show it is being put into practice at ward level, for the benefit of patients.

NHS Fife’s self-assessment states that it is committed to improving care of older people in acute hospitals and this can be evidenced through the work of the inspection co-ordinating group. This remit of this group is to oversee work streams involved in the care of older people, scrutinise improvement activity and ensure that national and local standards are achieved and sustained. The group meets every fortnight and is attended by senior management, including the director of acute services, general managers, heads of nursing, allied health professionals, and estates and facilities managers.

There was clear leadership and team working within the majority of wards inspected. Staff reported that they felt supported and that senior management were visible. During previous inspections to Victoria Hospital, we had concerns about ward 15 regarding the care of older people. During this inspection, it was clear that significant improvements have been made. Ward 15 is now working more closely with the other care of elderly ward (ward 12) to ensure
that care is consistent. The clinical nurse manger and senior staff from ward 12 have supported ward 15 during recruitment of the recently vacant senior charge nurse post. During the inspection, a group of senior charge nurses asked to meet with the inspection team to raise concerns regarding patient flow and capacity and the effect this has on the quality of care of patients in the hospital. This has been raised to senior management within NHS Fife and work has been undertaken to resolve these issues. We look forward to seeing the outcome of this at future inspections.

Area of good practice

■ There is clear, strong leadership from senior charge nurses and clinical nurse managers in Victoria Hospital.
Appendix 1 – Areas for improvement

Areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action.

The list of national standards, guidance and best practice can be found in Appendix 3.

Treating people with compassion, dignity and respect

<table>
<thead>
<tr>
<th>NHS Fife:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>should continue to review and formally monitor patient movement within Victoria Hospital. In particular, the NHS board must monitor compliance with the standard operating procedure for boarding relating to moving patients with cognitive impairment for non-clinical reasons (see page 11).</td>
</tr>
</tbody>
</table>

Screening and initial assessment

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Fife:</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>must ensure that nutritional screening is carried out for all patients within 24 hours of admission. Nutritional rescreening must also be carried out weekly, or according to patient condition (see page 16). This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criteria 2.1, 2.2 and 2.3 of the 2014 of the Food, Fluid and Nutrition Standards.</td>
</tr>
<tr>
<td>3</td>
<td>should ensure that documentation is standardised throughout the hospital and a consistent approach is applied (see page 16).</td>
</tr>
</tbody>
</table>

Person-centred care planning

<table>
<thead>
<tr>
<th>Outcome 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Fife:</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patient’s condition or needs (see page 17). This is to comply with Standards of Care for Dementia in Scotland, page 15, Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.7 and Best Practice Statement for the Prevention and Management of Pressure Ulcers, Section 4.</td>
</tr>
</tbody>
</table>
Safe and effective care

Outcome 5

NHS Fife:

5  should continue to develop and rollout delirium improvement work within Victoria Hospital (see page 20).

6  should ensure that assessment of capacity treatment plans are in place to reflect proposed interventions and these are documented as being discussed with the patients’ families (see page 20).

Outcome 6

NHS Fife:

7  must ensure that food and fluid balance charts are commenced and accurately completed for patients who require them and appropriate action is taken in relation to intake or output, as required (see page 23).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criteria 2.5 and 4.1 (g)

Outcome 8

NHS Fife:

8  must ensure that wound charts and any related documentation are in place for those patients with a known pressure ulcer or break in skin integrity to support safe and effective care delivery. This must include recording the severity and grade of any pressure ulcers and a clear plan of management. Documentation must be appropriately and consistently completed and be easily accessible (see page 25).

This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, Section 4.

9  must ensure that when a SSKIN bundle is implemented, a care plan is in place which identifies all the patient’s individual needs in relation to preventing and managing pressure ulcers and clearly demonstrates how those needs are to be met (see page 25).

This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, Section 4.

Managing the return home

Outcome 9

NHS Fife:

10  should ensure that any decisions made about discharge planning are clearly recorded on the discharge documentation (see page 26).

Healthcare Improvement Scotland Unannounced Inspection Report (Victoria Hospital, NHS Fife): 17–19 February 2015
Appendix 2 – Details of inspection

The inspection to Victoria Hospital, NHS Fife was conducted from Tuesday 17 to Thursday 19 February 2015.

The inspection team consisted of the following members:

Ian Smith
Senior Inspector

Claire Blackwood
Inspector

Kenneth Crosbie
Inspector

Irene Robertson
Inspector

John Dally
Public Partner

Marguerite Robertson
Public Partner

Supported by:

Jill Sands
Project Officer
Appendix 3 – List of national guidance

The following national standards, guidance and best practice are relevant to the inspection of the care provided to older people in acute care.

- Best Practice Statement for Prevention and Management of Pressure Ulcers (NHS Quality Improvement Scotland, March 2009)
- Clinical Standards for Food, Fluid and Nutritional Care in Hospitals (NHS Quality Improvement Scotland, September 2003)
- Clinical Standards for Older People in Acute Care (Clinical Standards Board for Scotland, October 2002)
- Dementia: decisions for dignity (Mental Welfare Commission, March 2011)
- National Standards for Clinical Governance and Risk Management (NHS Quality Improvement Scotland, October 2005)
- Scottish Intercollegiate Guidelines Network (SIGN) Guideline 86 – Management of Patients with Dementia (SIGN, February 2006)
- SIGN Guideline 111 – Management of Hip Fracture in Older People (SIGN, June 2009)
- Standards of Care for Dementia in Scotland (Scottish Government, June 2011)
Appendix 4 – Inspection process flow chart

This process is the same for both announced and unannounced inspections.

Before inspection:
- Self-assessment framework finalised and issued
- NHS board undertakes self-assessment exercise and submits outcomes to Healthcare Improvement Scotland
- Healthcare Improvement Scotland reviews self-assessment submission to inform and prepare on-site inspections

During inspection:
- Arrive at hospital
- Inspections of selected wards and departments
- Individual discussions with senior staff or operational staff, or both, and patients
- Group discussions with NHS board and senior hospital staff
- Feedback with NHS board and senior hospital staff
- Further inspection of hospital if areas of significant concern identified

After inspection:
- Report and improvement action plan published
- Follow-up activity to ensure improvement actions are completed
## Appendix 5 – Terms we use in this report

### Terms and abbreviations

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>accident and emergency</td>
</tr>
<tr>
<td>AHP</td>
<td>allied health professional</td>
</tr>
<tr>
<td>AWI</td>
<td>adults with incapacity</td>
</tr>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
</tr>
<tr>
<td>DNACPR</td>
<td>do not attempt cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>HDL</td>
<td>Health Department Letter</td>
</tr>
<tr>
<td>ICASS</td>
<td>integrated community assessment and support service</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>MUST</td>
<td>Malnutrition Universal Screening Tool</td>
</tr>
<tr>
<td>NG</td>
<td>nasogastric</td>
</tr>
<tr>
<td>PURA</td>
<td>pressure ulcer risk assessment</td>
</tr>
<tr>
<td>SBAR</td>
<td>situation, background, assessment, recommendation</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
<tr>
<td>SSKIN</td>
<td>skin, surface, keep moving, incontinence, nutrition</td>
</tr>
<tr>
<td>TIME</td>
<td>think, investigate, management, engage and explore</td>
</tr>
</tbody>
</table>
How to contact us

You can contact us by letter, telephone or email to:

- find out more about our inspections, and
- raise any concerns you have about care for older people in an acute hospital or NHS board.

**Edinburgh Office** | Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB

**Telephone** 0131 623 4300

**Email** hcis.chiefinspector@nhs.net

www.healthcareimprovementscotland.org

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Medicines Consortium (SMC) and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.